TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Consultants in Pain Medicine

Respondent Name
Travelers Indemnity Co of Conn

MFDR Tracking Number
M4-17-3232-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 80307 is a new code that replaced G0479. Note new code implemented on 01/01/17. Please review notes requested and reprocess our claim."

Amount in Dispute: $98.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0481 reimbursed under this date of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services. Further, the Provider failed to submit required documentation with the billing."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2017	80307	$98.85	$76.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - W3 – Additional payment made on appeal/reconsideration
   - 6578 – Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed

Issues

1. Did the carrier raise a new issue?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule that applies to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "Further, the Provider failed to submit required documentation with the billing. The Medicare coding edits require that the doctor's order for urine drug screening be submitted with the billing."

   Texas Administrative Code §133.307 (2) states,

   > Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:
   >
   > > (F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

Review of the submitted explanation of benefits finds insufficient evidence to support the Carrier presented the denial for "required documentation not submitted with billing" prior to the date the MFDR was filed. Therefore, the Carrier's position statement will not be considered in this dispute.

2. The requestor is seeking reimbursement for professional medical services rendered on March 20, 2017 in the amount of $98.85. The carrier denied as 6578 – "Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code."

   Review of the submitted medical bill lists the following codes:

   - 80307 – Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
   - G0481 - Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples

(e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed

Review of CHAP10-CPTcodes80000-89999_final103116.doc, Revision Date: 1/1/2017, CHAPTER X PATHOLOGY / LABORATORY SERVICES, CPT CODES 80000 – 89999, FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

E. Drug Testing

Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

28 Texas Administrative Code 134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers.

Insufficient evidence was found to support the service in dispute is part of a panel or that a CCI edit exits. Therefore, the carrier's denial is not supported. The service in dispute will be reviewed per applicable fee guidelines below.

3. 28 Texas Administrative Code 134.203 (e) states in pertinent part,

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

The 2017 Clinical Diagnostic Laboratory Fee Schedule indicate the allowable for Code 80307 is $61.02. This amount multiplied by 125% ($61.02 x 125%) = $76.28. There is not a professional component therefore the Maximum Allowable Reimbursement is $76.28. This amount is recommended.

4. The Division finds per the applicable Medicare payment policy, the requestor submitted a medical claim line that is separately payable and the MAR of $76.28 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $76.28.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $76.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.